STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155596	A. BUILDING _____ B. WING _____	C 04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND SKILLED NURSING AND REHABILITATION	**500 N WILLIAMS ST ANGOLA, IN 46703**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaint IN00147244.

Complaint IN00147244 - Substantiated. No deficiencies related to the allegations are cited.

Survey dates: April 9, and 10, 2014

Facility number: 000474
Provider number: 155596
AIM number: 100290510

Survey team:
Christine Fodrea, RN, TC

Census bed type:
SNF: 3
SNF/NF: 63
Total: 66

Census payor type:
Medicare: 18
Medicaid: 34
Other: 14
Total: 66

Sample: 3

Lakeland Skilled Nursing and Rehabilitation was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint IN00147244.

Quality Review 04/11/14 by Lisa McColly

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE